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SENATE BILL 1502
By Rochelle

AN ACT to amend Tennessee Code Annotated, Title 29, Chapter 26 and Title 56, Chapter 32, relative to health maintenance organizations.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-32-202, is amended by inserting the following definitions as new, appropriately designated items:

(__) "Adverse decision" means a utilization review determination by or on behalf of a plan that a requested service or benefit is not medically necessary under the plan contract and such determination results in a documented denial or nonpayment of the otherwise covered service or benefit.

(__) "Appeals decision" means a final decision made by the grievance review committee pursuant to Section 56-32-210.

(__)

(A) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding:

(i) Availability or delivery of health care services;

(ii) Claims payment or reimbursement for health care services; or

(iii) Matters pertaining to the terms and conditions of the contractual relationship between a covered person and the health maintenance organization.

(B) "Grievance" does not include inquiries about any of these matters.

(__) "Harm" means that harm which is proximately caused by the failure of a plan to exercise ordinary and reasonable care and which is reasonably related to the enrollee's medical condition.

(__) "Ordinary and reasonable care" means, in the case of a plan, the degree of care in making a determination of medical necessity that a plan of ordinary and reasonable prudence would use under the same or similar circumstances. For a person who is an agent of a plan, "ordinary and reasonable care" means the degree of care that a person of ordinary and reasonable prudence would use under the same or similar circumstances.

(__) "Plan" means a health maintenance organization authorized to conduct business under Tennessee Code Annotated, Title 56, Chapter 32.

SECTION 2. Tennessee Code Annotated, Section 56-32-202, is further amended by adding at the end of item (4) before the "." the following: "and who is contractually entitled to receive benefits or services under a plan".

SECTION 3. Tennessee Code Annotated, Section 56-32-210, is deleted in its entirety and replaced by the following new section:

56-32-210. Internal Grievance System.

(a)

(1) A plan shall maintain a grievance system and shall maintain written documentation regarding grievances containing, at a minimum, the following information:

(A) A category generally describing the reason for the grievances;

(B) Date received;

(C) Date of review;

(D) Resolution of grievance;

(E) Date of resolution; and

(F) Name of the covered person for whom the grievance was filed.

(2) The grievance register shall be maintained in a manner that is reasonably clear and accessible to the commissioner.

(3) The grievance register shall be retained for the longer of three (3) years or until the commissioner has adopted a final report of an examination that contains a review of the grievance register.

(b) A plan shall use written procedures for receiving and resolving grievances from covered persons.

(1) The grievance procedure and any material modifications thereto shall be filed with the commissioner for approval. Upon request, supporting documentation shall be filed with the commissioner. In addition, the plan shall file annually with the commissioner a certificate of compliance. The certificate must state that the plan has established and maintained grievance procedures that fully comply with the provisions of this section.

(2) A description of the grievance system shall be set forth in or attached to the policy or evidence of coverage provided to enrollees.

(3) The grievance system shall include a statement of an enrollee's right to contact the commissioner's office for assistance at any time. The statement shall include the telephone number and address of the commissioner.

(c)

(1) In response to any inquiry from an enrollee regarding a denied claim, which inquiry is not a grievance, the plan shall provide an outline of the grievance

procedure and the enrollee's right to seek review by the commissioner pursuant to subparagraph (7)(A).

(2) A grievance review committee shall be established by the plan. The committee shall not include a person whose decision is being appealed or who made the initial determination denying a claim or handling a grievance. The review shall be held within ten (10) working days of receipt of the grievance and all necessary information; provided, this time may be extended by written notice to the enrollee that review cannot be accomplished within ten (10) working days, such extension not to exceed an additional ten (10) working days. The plan shall provide to the enrollee the name, address and telephone number of a person designated to coordinate the grievance review on behalf of the plan upon receipt of the grievance.

(3) The enrollee is entitled to submit written material and may have the assistance of an uninvolved member of the staff. The plan shall make these rights known to the enrollee upon receipt of the grievance.

(4) A written decision shall be issued to the enrollee or the enrollee's representative within five (5) working days from the date of the review. The written decision shall contain:

(A) A statement of the grievance committee's understanding of the enrollee's grievance;

(B) The committee's decision in clear terms of sufficient detail including the contract basis or rationale for the decision; and

(C) A reference to the documentation and information used as the basis for the decision.

(5) The procedures described in subparagraphs (c)(2), (4) and (6) shall not apply to life threatening conditions in which event the enrollee is granted the rights provided by 56-32-227.

(6) An enrollee may request that the grievance review committee reconsider its initial decision by notifying the plan in writing within thirty (30) days of receiving the committee's written decision. Upon receipt of such a request, the committee shall reconsider the grievance in accordance with the requirements of paragraph (2) above. Upon requesting such reconsideration, an enrollee may submit, for the committee's consideration, additional written material pertinent to the grievance.

(7)

(A) After receiving either the initial decision by a grievance committee, or a decision upon reconsideration by a grievance committee, an enrollee may seek review of the matter by the commissioner or a designee of the commissioner. The commissioner or the commissioner's designee may consult with medical personnel in the department of health for grievances that involve primarily questions of medical necessity or medical appropriateness. Such review by the commissioner or designee shall be initiated by the enrollee's submitting to the commissioner and the plan a written request for review within thirty (30) days of the date of either the initial decision or decision on reconsideration by a grievance committee. The commissioner or designee shall review the file of the plan and any other information submitted by either the plan or the enrollee.

(B) The results of the review by the commissioner or designee shall be in written form and a copy thereof shall be provided to both the plan and the enrollee. Review by the commissioner or designee in accordance with this subparagraph shall not be a contested case under Section 4-5-301, and shall not preclude either the enrollee or the plan from initiating judicial proceedings. The results of the review by the

commissioner or designee shall not be admitted as evidence in any judicial proceeding.

(8) This section does not apply to the TennCare program, which operates under a federal waiver pursuant to title 71.

SECTION 4. Tennessee Code Annotated, Section 56-32-227, is deleted in its entirety and replaced by the following new section:

56-32-227. Independent Review.

(a) Upon written request, an enrollee has the right to an independent review of an adverse decision made by or on behalf of a plan in accordance with the requirements of this section.

(1) Every plan shall provide an independent review process to examine any adverse decision made by the plan for an enrollee if:

(A) The enrollee has exhausted the plan's appeals procedures as required by Section 56-32-210 by requesting review and reconsideration by the plan's grievance review committee and received an appeals decision; provided, however, that an enrollee shall not be required to complete the internal grievance process pursuant to Section 56-32-210 before initiating the independent review process required by this section if the enrollee has an imminently life threatening condition, as determined by the enrollee's physician, or if the plan has failed to make an appeals decision within the time period required; and

(B) The proposed service or treatment would require the plan to incur five hundred dollars ($500) or more of expenditures on a cumulative basis to cover such service or treatment.

(2) The independent review process shall meet the following criteria:

(A) The plan shall offer all enrollees who meet the criteria in paragraph (a)(1) the opportunity to have the adverse decision reviewed

under the independent review process. The plan shall notify eligible enrollees in writing of the process to request an independent review at the time of the final appeals decision to deny coverage. The enrollee may file a written request for independent review with the plan no later than sixty (60) days after receiving such notification.

(B) The enrollee shall be required to pay a one-time fee of fifty dollars ($50.00) toward the cost of the independent review, payable at the time the enrollee requests the independent review.

(C) The plan shall provide to the independent review entity a copy of the following documents within five (5) business days of the plan's receipt of a request by an enrollee or the enrollee's physician for an independent review:

(i) Any information that was submitted to the plan by the enrollee or the enrollee's physician in support of the enrollee's request for coverage under the plan's appeals procedures. The confidentiality of any medical records submitted by the plan shall be maintained pursuant to applicable state and federal laws.

(ii) A copy of the contract provisions upon which the denial of coverage was based, any other relevant documents used by the plan in determining whether the proposed service or treatment should be covered, and any statement by the plan explaining the reasons for the plan's decision not to provide coverage for the proposed service or treatment. The plan shall provide, upon request, a copy of documents required by this subparagraph, except for any legally privileged information, to the enrollee and the enrollee's physician. The independent review entity shall

maintain the confidentiality of plan information identified as proprietary.

(D)

(i) The independent review entity shall notify the enrollee and the enrollee's physician of any additional medical information required to conduct the review within five (5) business days of receipt of the documentation required under subparagraph (2)(C).

(ii) The plan shall be notified of this request. The enrollee and the enrollee's physician shall submit the additional information, or an explanation of why the additional information is not being submitted, to the independent review entity and the plan within five (5) business days of the receipt of such a request.

(iii) The plan may, at its discretion, determine that additional information provided by the enrollee or the enrollee's physician justifies a reconsideration of its coverage denial, and a subsequent decision by the plan to grant coverage shall terminate the independent review upon notification to the independent review entity. The enrollee shall be entitled to any refund of payment required under subparagraph (2)(B) should the independent review be terminated under this subparagraph.

(E) The independent review entity shall submit the expert determinations to the plan, the enrollee, and the enrollee's physician within thirty (30) days of the receipt of the request for review, except that for imminently life-threatening conditions, as determined by the enrollee's physician, the determinations shall be submitted within five (5) business days of the receipt of the request for review. At the request of the expert, the deadline shall be extended by up to five (5) business days for the

consideration of additional information requested under subparagraph (2)(D).

(F) The independent review entity's determination shall be in written form and state the reasons the requested service or treatment should or should not be covered under the terms and conditions set forth in the evidence of coverage. The independent review entity shall make determinations based on the applicable coverage documents, including any defined terms that are provided for thereunder, such as "medically necessary," and shall not expand the contractually agreed upon coverage. The independent review entity's determinations shall specifically cite the relevant provisions in the evidence of coverage, the enrollee's specific medical condition, and the relevant documents provided pursuant to subparagraphs (2)(C) and (D), to support the independent review entity's determination.

(G) The plan shall have written policies describing the independent review process. The plan shall disclose the availability of the independent review process and how enrollees may access the review process in the plan's evidence of coverage.

(H) Coverage for the services required under this section shall be provided subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the plan. Nothing in this section shall be construed to require the plan to pay for the services that are not otherwise covered pursuant to the evidence of coverage under the plan.

(b) The plan may contract with only those independent review entities meeting the following requirements:

(1) Expert reviewers assigned by independent review entities must be physicians or other appropriate providers who meet the following minimum requirements:

(A) Expert in the treatment of the enrollee's medical condition, and knowledgeable about the recommended service or treatment through actual clinical experience;

(B) Hold a non-restricted license in a state of the United States, and for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of review; and

(C) Have no history of disciplinary actions or sanctions (including, but not limited to, loss of staff privileges or participation restriction) taken or pending by any hospital, government or regulatory body.

(2) The independent review entity shall not be a subsidiary of, nor in any way owned or controlled by, a health plan, a trade association of health plans, or a professional association of health care providers.

(3) Neither the expert reviewer, nor the independent review entity, has any material professional, familial, or financial conflict of interest with any of the following:

(A) The plan;

(B) Any officer, director, or management employee of the plan;

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the service or treatment;

(D) The institution at which the service or treatment would be provided; and

(E) The development or manufacture of the principal drug, device, procedure, or other therapy proposed for the enrollee whose treatment is under review.

(4) The term "conflict of interest" shall not be interpreted to include a contract under which an academic medical center, or other similar medical research center, provides health services to plan enrollees, except as subject to the requirement of paragraph (b)(3)(D); affiliations which are limited to staff privileges at a health facility; or an expert reviewer's participation as a contracting plan provider where the expert is affiliated with an academic medical center, or other similar medical research center, that is acting as an independent review entity under this section.

(5) The independent review entity shall have a quality assurance mechanism in place that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts, and the confidentiality of medical records and review materials.

(6) An independent review entity and an expert reviewer assigned by the entity to conduct a review under this section are not liable for damages arising from the determinations made pursuant to this section. This subparagraph does not apply to an act or omission of the independent review entity that is made in bad faith or that involves gross negligence.

(7) The determination of the independent review entity shall be binding on the plan.

SECTION 5. Tennessee Code Annotated Section, 56-32-208, is amended by re-designating the existing paragraph as subsection (a) and inserting the following new subsection thereafter as follows:

(b) Each plan shall submit to the commissioner an annual report, in a form and by a date prescribed by the commissioner, which shall include:

(1) A description of the procedures for the internal grievance system required by Section 56-32-210, the total number of complaints handled through the internal grievance system, a compilation of causes underlying the complaints and indication as to whether the complaint was decided for or against the covered person; and

(2) A description of the independent review process required by Section 56-32-227, the total number of requests for independent review received by the plan and information as to the number of independent review decisions which were favorable to the plan and how many were favorable to covered persons requesting independent review.

(c) The information submitted by a plan pursuant to subsection (b) shall not include any consumer identifying information or information considered confidential under state and federal laws.

SECTION 6. Tennessee Code Annotated, Title 56, Chapter 32, is amended by creating a new appropriately designated section.

56-32-237. Plan Liability and Cause of Action.

(a) An enrollee may maintain a cause of action against a plan if the enrollee suffers harm when the plan fails to exercise ordinary and reasonable care when making an adverse decision.

(b) An enrollee may not maintain a cause of action under this subsection unless the enrollee or the enrollee's representative:

(1) Has exhausted all appeal procedures described in the evidence of coverage and disclosure form under the plan, and has requested and received a final decision pursuant to Section 56-32-210; and,

(2) Has requested and received a decision by an independent review entity pursuant to Section 56-32-227.

(c) An action under this subsection is governed by the statute of limitations in Section 29-26-116.

(d) A decision by an independent review entity made in accordance with the independent review process, in favor of the plan, shall create a presumption that the plan exercised ordinary care. The enrollee may rebut this presumption with clear and convincing evidence.

(e) It is an affirmative defense to any action asserted against a plan under this section that the plan or any agent for whose conduct the plan is liable did not control, influence or participate in the provision of health care services.

(f) In a cause of action under this subsection, the award of damages must be made in accordance with this subsection.

(1) Actual or compensatory damages may be awarded.

(2) Noneconomic damages awarded may not exceed three hundred thousand dollars ($300,000).

(3) Punitive damages may not be awarded.

(g) Attorney's fees to be charged to a plaintiff shall be subject to the approval of the court in which the action is heard; provided, however, in no event shall such fees be in excess of thirty-three and one-third percent (33 1/3%) of the amount of the award of damages.

(h) All causes of action brought under this section must be filed within one (1) year of the independent review decision.

(i) This subsection does not create any new or additional liability on the part of a plan for harm caused to an enrollee that is attributable to the professional negligence of a treating physician or other health care practitioner.

(j) This subsection does not create any liability on the part of an employer that assumes risk on behalf of its employees or an employer group purchasing organization.

(k) The cause of action under this subsection is the sole and exclusive private remedy under Tennessee law for an enrollee against a plan for its adverse decisions, except that this subsection may not be construed to prohibit an enrollee or an enrollee's authorized representative from seeking other remedies specifically available under other provisions of this title or pursuant to the plan contract.

(l) The provisions of subsection (c) shall be applicable to enrollees of plans providing services to such enrollees through the TennCare program; provided, however, prior to maintaining a cause of action as provided in subsection (a), in lieu of the processes for grievances and appeals under Section 56-32-210 and the independent review process provided under Section 56-32-227, a TennCare enrollee shall have exhausted all available complaint and review processes provided under contracts between the plan and the TennCare program, and under policies, procedures, rules and regulations of the TennCare program applicable to such enrollee.

SECTION 7. Tennessee Code Annotated, Section 29-26-116(a), is amended by inserting between the word “actions” and the word “shall” the following phrase: “and actions against a health maintenance organization pursuant to Title 56, Chapter 32".

SECTION 8. This act shall take effect upon becoming a law, the public welfare requiring it; provided, however, Section 6 of this act shall apply only to adverse decisions made on or after January 1, 2002.